DEPARTMENT OF HEALTH
Council of Licensed Midwifery

APPLICATION FOR 4-MONTH PRE-LICENSURE COURSE

Department of Health
Council of Licensed Midwifery
4052 Bald Cypress Way – BIN #C06
Tallahassee, FL 32399-3256
(850) 245-4565

DEPARTMENT OF HEALTH
COUNCIL OF LICENSED MIDWIFERY
APPLICATION CHECKLIST

This checklist is a guide to assist you in submitting the required documentation to determine 4-Month Pre-licensure Course eligibility. Please make a copy of documentations for your records, prior to mailing the originals to the department.

Within 30 days from receipt of your application and fee you will be notified via mail of your application status. If you do not receive notification within 40 days from receipt of your application, please contact our office.

Documentation Applicants Must Submit

- ❑ Complete application, please print clearly or typed.
- ❑ Cashiers Check or money order made payable to the Department of Health.
  Determination of Eligibility for 4-Month Pre-licensure Course
  - Application Fee $100.00 (**non-refundable**)
- ❑ Complete the "Confidential and Exempt from Public Records Disclosure" form.
- ❑ One full-faced passport type photograph (size 2X2) taken within the past six months.
- ❑ Official documentation of name change (if applicable)
- ❑ High School Diploma or Equivalent
- ❑ Official transcript from an approved midwifery training program
  - All courses successfully completed
  - Date of graduation _____
  - Degree, certificate or diploma granted _____

Official midwifery training/program documentation

Another State:

- ❑ Official certificate or diploma from a midwifery program approved by the certifying body of the state in which it was located
- ❑ Official transcript from the midwifery program which documents classroom instructions and clinical training

Another County:

- ❑ Certified official certificate or diploma from a foreign institution of medicine or foreign school of midwifery AND a certified translation of the foreign certificate or diploma when applicable.
- ❑ Certified copy of document rendering applicant eligible to practice medicine or midwifery in the country where document was issued AND certificate translation of that same document when applicable.

*****All candidates wishing to take the examination must apply directly to the North American Registry of Midwives (NARM). Please contact NARM's testing center at 1-888-353-7089 for examination application and information.***

DEPARTMENT OF HEALTH
COUNCIL OF LICENSED MIDWIFERY
APPLICATION INSTRUCTIONS FOR LICENSURE

The following instructions are numbered so that they correspond with the numbered sections of the application. Each instruction gives specific information regarding the corresponding section of the application. It is recommended that you maintain a copy of the instructions and application should you need to refer to them during the application process. A response must be provided in each section. If a question does not pertain to you indicate "N/A" in that section. All questions with "YES/NO" answers must have either "YES" or "NO" marked. No other response is acceptable.

One (1) photograph is required for applicants applying to determine 4-Month Pre-licensure Course eligibility. It is requested that the photograph be 2"x 2" and be a full front shot of your head and shoulders. Informal snapshot are not acceptable. The picture must have been taken within 6 months of the date of application. Please staple photograph to the front page of application.

ADDITIONAL SPACE NOTE: If any of the sections in the application do not contain sufficient space for the requested information, use an additional page or the reverse side of the application page on which the question is located.

1 -Names: List your full last name. Type a hyphenated last name in the same space. A hyphenated last name will be recognized by the first letter of the first name (i.e.) Diaz-Balart will be filed under Diaz. List your full first name, no nicknames or shortened versions. List your full middle name, if you have one. If you have two, type them in the same space. If you do not have a middle name please indicate N/A.

2-6 - List your Date of Birth, Place of Birth, Home/Work Telephone Number and E-Mail Address.

7 - Mailing address: This should be the address where you will receive correspondence we send regarding your file.

8 - Physical/Primary Practice Address: This should be the address where you are currently practicing or where you can be physically located. NOTE: Do not list P.O. Boxes. In the event that either of your addresses changes during the application process, submit the new address(s) immediately.

9 -Name Changes: If you have ever changed your name by marriage or other court action, you must submit a copy of legal documentation of the change with your application (if you have been married more than once all marriage and divorce documents must be submitted.) List your maiden name in the space provided. NOTE: If you use any names other than your legal name, but have not legally changed your name, list such name(s) in the space provided under "other" in this section. If you are married but use a maiden name professionally, please indicate this.

10 - Response to this section is voluntary.

11 - List your U.S. Citizenship. If No, you must provide your alien number.

12 - Provide the name, location, dates attended and degree earned of where you attended high school or where you received your general equivalency diploma.

13 - Provide the name, location, dates attended and degree earned of the midwifery school(s) you attended. Submit a notarized copy of the diploma. If the degree is in any language other than English it

must be accompanied by a certified translation of that degree.

14 - Provide the name, location, dates attended and degree earned for all post-secondary, health care, and/or medical education training. Provide a copy of the diploma. If the degree is in any language other than English it must be accompanied by a certified translation of that degree. List the programs chronologically starting with the first program attended and ending with the last (or current) program attended.

15 - **This section of the application must be completed**. The applicant's name must be printed in the first blank and signed in the second blank. This section will be copied and used as a release of information when needed; therefore, the signature must be a full signature to be acceptable.

You must notify us immediately of any occurrences which would change or affect in any way, an answer or response you have given in the application. Failure to do so could result in the denial of your application or revocation of your license.

A cashier's check or money order must accompany the application for processing. If your application is not completed within one year, it will expire and a new application will be required. Should an applicant be deemed ineligible for the 4-Month Pre-licensure Course, **the application fee is nonrefundable**.

Where to send the application: The original application, fee and supporting documentation should be sent **in the same envelope** to:

Department of Health
Council of Licensed Midwifery
Post Office Box 6330
Tallahassee, FL 32314-6330

The use of this address will ensure the receipt of the application by the office where the fees will be processed. The application and supporting documentation will then be logged in and forwarded to the Council office.

Where to send supporting documentation not sent with the application: Any additional documentation, sent either by yourself or by another individual for you, which was not submitted with the original application, should be mailed to the following address:

Council of Licensed Midwifery
4052 Bald Cypress Way, Bin #C06
Tallahassee, FL 32399-3256

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health

Name: _____
Last **First** **Middle**

Social Security Number: _____

* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

4052 Bald Cypress Way, Bin # C-06
Tallahassee, Florida 32399-3257
Website: www.doh.state.fl.us/mqa/

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(For Official Use Only)

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Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? [ ] Yes [ ] No

1. Last Name First Name Middle Name

2. Date of Birth	3. Place of Birth (City, State, Country)
4. Home Telephone Number ( )	5. Work Telephone Number ( )

6. E-mail Address

7. Mailing Address

8. Physical Address

9. Name Changes or Aliases [ ] No [ ] Yes (If yes, please list below)
Maiden Name: Other:

10. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 60-3, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38295 (August 25, 1978). This information is gathered for statistical purposes only and does not affect your candidacy for licensure in any way.

Sex: [ ] Female [ ]Male
Ethnic Origin: [ ] White [ ] Black [ ] Hispanic [ ] Oriental [ ] Native American
[ ] Other; Explain

11. Are you a United States Citizen? [ ] Yes [ ] No; Provide Alien #

12. **HIGH SCHOOL EDUCATION OR EQUIVALENCY**		
Name and Location of School	Dates Attended	Degree

13. **MIDWIFERY EDUCATION**		
Name and Location of School	Dates Attended	Degree

14. **POST-SECONDARY, HEALTHCARE OR MEDICAL EDUCATION** (does not apply indicate N/A)			
Name of Institution	Full Mailing Address	Dates Attended	Degree

15. **SIGNATURE OF APPLICANT**

I, (Print your name) _____, state that I am the person referred to in the foregoing application and supporting documentation, that said application and any supporting documentation are true and accurate and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions, organizations, references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health any information, files or records requested by the Department in connection with the processing of this application. I further authorize the Department of Health to release to the organizations, individuals and/or groups listed above any information which is material to my application.

I affirm that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education requirements.

I have carefully read the questions in the foregoing application and have answered them completely and without reservations of any kind. I declare that my answers and all statements made by me herein are true and correct. Should I knowingly make a false statement in writing with the intent to mislead a public servant in the performance of their official duty, I shall be guilty of a misdemeanor in the second degree punishable as provided in Chapter 775.082, 775.083, or 775.084, Florida Statutes.

_____ _____

Signature of Applicant Date Signed